



Michigan  
*Office of the Auditor General*  
**REPORT SUMMARY**

*Performance Audit*

*Northville Psychiatric Hospital (NPH) and  
Related Closure Activities  
Bureau of Hospitals, Centers, and Forensic  
Mental Health Services  
Department of Community Health (DCH)*

Report Number:  
39-240-03

Released:  
February 2005

*NPH was established in 1952. Its mission was to provide a comprehensive array of high-quality inpatient psychiatric services to adult persons with mental illness. On November 18, 2002, DCH announced that it would close NPH. As of May 16, 2003, NPH had placed all of its patients in a community setting or transferred them to other State-run psychiatric facilities. As of December 2003, NPH closing staff were still in the process of disposing of NPH's equipment, furnishings, and supplies and securing patient, administrative, and accounting records.*

***Audit Objective:***

To assess the effectiveness and efficiency of DCH's and NPH's oversight of selected NPH operational and closure activities.

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***Audit Conclusion:***

We determined that DCH's oversight and NPH's oversight of selected NPH operational activities were not effective. Also, we determined that DCH's oversight and NPH's oversight of selected NPH closure activities were somewhat effective and efficient.

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***Material Conditions:***

DCH did not ensure that NPH established effective controls over its purchasing, receiving, and payment processes. The material weaknesses in NPH's controls unnecessarily elevated NPH's risk for fraud and abuse, permitted unauthorized expenditures, allowed NPH to overpay for

some of the goods and services that it purchased, and resulted in inefficient transaction processing. (Finding 1)

DCH did not ensure that NPH effectively utilized, accounted for, and controlled its equipment and furnishings. As a result, a large quantity of NPH's unused equipment and furnishings became worthless while in storage. In addition, the lack of effective controls increased the risk that misappropriation of State-owned property occurred and was not detected. (Finding 2)

DCH did not ensure that NPH had established effective controls over its medication supplies. As a result, NPH could not account for the receipt and disposition of the medications it purchased. (Finding 3)

DCH did not ensure that NPH obtained required inspections for its high-pressure, high-temperature boilers or periodically

tested the reliability of its backup system for fueling these boilers. These shortcomings may have jeopardized the safety and well-being of NPH and Hawthorn Center (HC) patients and staff. (Finding 4)

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**Reportable Conditions:**

DCH did not ensure that NPH complied with various Department of Management and Budget and DCH policies, procedures, and directives governing the use of State procurement cards (Finding 5).

DCH's closing procedure did not provide adequate direction to NPH closing staff for the effective and efficient inventory and subsequent transfer or disposal of NPH's equipment and furnishings (Finding 6).

DCH did not ensure that NPH appropriately accounted for the unused medications that it returned for refund upon its closure (Finding 7).

DCH did not ensure that HC paid NPH for the cost of the electricity, water and sewer service, and steam that NPH provided to it (Finding 8).

DCH did not ensure that NPH established effective controls over its supplies inventory (Finding 9).

DCH did not ensure that NPH effectively controlled access to and accounted for usage of its gasoline and diesel fuel (Finding 10).

DCH did not ensure that NPH appropriately accounted for its Gifts, Bequests, and Donations Fund (Finding 11).

DCH did not ensure that NPH created and retained documentation to support its release of personal property belonging to some patients discharged during the closing process. In addition, DCH did not ensure that NPH promptly released personal property belonging to patients discharged prior to the closing process. (Finding 12)

DCH did not ensure that NPH executed contracts with some of the vendors from which it procured services (Finding 13).

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**Agency Response:**

Our audit report contains 13 findings and 23 corresponding recommendations. DCH's preliminary response indicated that it agreed with all of our findings and agreed wholly or in principle with all of our recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: <http://audgen.michigan.gov>



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